# A NOTE ON WAR PSYCHIATRY*

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AT the time of our joining our allies in the first World War, American Psychiatry had the advantage of scrutinizing the experiences of the other combatant nations on both sides of the struggle with respect to the psychiatric issues involved. Our attention was challenged by two important facts which were reflected in the published accounts of the medical authorities of the nations at war: First, the substantially greater prevalence of psychiatric casualties among soldiers than among the civilian population, and second, the emergence of new and hitherto unobserved disorders of function which were in a general way referable to the nervous system.

With respect to the first observation, namely, the markedly increased incidence of psychiatric casualties among troops, it was observed that not only in actual war but even during peaceful mobilization, such as that of our army along the Mexican border in 1916, there was a higher rate of mental disease among soldiers than in civil life. The discharge rate for mental diseases in the United States Army in 1916 was three times the admission rate for these disorders in the adult male population of the State of New York, one-tenth of all discharges for disability being for mental diseases, mental deficiency, epilepsy and the neuroses.

It was largely through the efforts of the late Thomas W. Salmon that the significance of these observations was brought to the attention of the medical authorities of the War Department, which up to then had shown relatively little concern in psychiatric issues. As a result largely of Salmon's efforts, the coöperation of the Army Medical authorities was gained for putting into practice the recommendations outlined by a group of psychiatrists and neurologists under Salmon's leadership. It was my privilege to participate in the early deliberations on these matters and I wish to take the opportunity here of attesting to the rare wisdom, courage and high qualities of leadership which Salmon displayed during

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these deliberations. It would serve no particular purpose to give a detailed account here of the clinical and administrative techniques which were finally adopted, although I shall go into greater detail later on with respect to the clinical aspects of the subject.

At the time of the creation of the Division of Neurology and Psychiatry in the Surgeon General's office, about fifty neuropsychiatric officers had been commissioned. Five months later there were two hundred and thirty-five, and at the time the armistice was signed there were 430 officers in this country and 263 overseas, a total of 693. I mention these figures in order to indicate the drain which the requirements of the Selective Service Administration will mean to civilian psychiatry. These officers were assigned in a general way to two types of duty: First, the routine neuropsychiatric examination of recruits, and second, clinical and administrative service in base and other military hospitals.

It was impossible to determine with absolute accuracy how many men were examined by the neuropsychiatrists in this country, but the figure finally adopted for statistical considerations was 3,500,000. Of this number there was a total of 69,394 psychiatric diagnoses, and of these 533 referred to officers and 587 to candidates for commission.

These psychiatric diagnoses comprised the following entities: 31.5 per cent mental deficiency; 16.5 per cent psychoneuroses; 11.4 per cent psychoses; 10 per cent nervous diseases and injuries; 9.2 per cent epilepsy; 8.9 per cent constitutional psychopathic states; 6.9 per cent endocrinopathies; 2.9 per cent drug addiction; 2.7 per cent alcoholism.

Thus 20 out of every 1000 examined had some form of mental or nervous disease or defect.

According to the British official history of the Great War, the psychiatric problem in the British Expeditionary Forces did not become acute until July 1916, when several thousand patients were rapidly passed out of the Somme battle zone. An analysis of 1,043,653 British casualties revealed that neuroses formed 34 per 1000 casualties. On occasions neuroses made up 40 per cent of the casualties evacuated home. In 1918 out of a total 160,000 pensioners, 32,000, or 20 per cent, were receiving pensions for functional nervous and mental disease, while in 1921 this figure had risen to 65,000. Of the 180,496 casualties which occurred in the Canadian Expeditionary Force, 24 per 1000 were included in the category of nervous and mental disease.

According to various authors, the incidence of psychiatric casualties

was relatively greater in fresh troops arriving in the front line; in battle-tested troops after prolonged trench life without a break; in men over 40, especially married men, and in rapidly trained volunteers as compared with the regular army. The incidence rose considerably after severe military operations, actively advancing troops were less liable to breakdown than inactive or retreating troops, technicians working at the front under extreme hazard, infantry and machine gunners, engineers, artillery and tank corps ranked high on the list.

It is interesting to compare the above ratios of casualties in the B. E. F. and C. E. F., 34 to 40 per thousand in the former and 24 per 1000 in the latter with the ratio of casualties in the A. E. F., where during the period between April 1917 and December 1919 it was 9.5 per 1000. One reason for this markedly lower incidence of psychiatric casualties among the A. E. F. that is frequently given, especially by foreign authorities, is the comparatively short period of active service that our forces had abroad. While this factor cannot be ignored, I would like to stress especially in this connection two other factors which account for this important difference in the ratio of casualties. The first is the really competent job which the neuropsychiatrists did in weeding out the incompetents on this side of the ocean. It is significant in this connection that 27,836 cases or 40.1 per cent of the total of 69,394 were detected and certified as unfit in the course of the routine neuropsychiatric examinations. Other sources of spotting the unfit were as follows: 31.6 per cent came to light as result of psychiatric consultations requested by other medical officers; 23.6 per cent were referred by commanding officers, non-medical. In connection with this truly significant item, namely that 16,336 cases of psychiatric abnormalities were detected by line officers, I would like to stress the great importance of a deliberate and well organized technique for educating non-commissioned as well as commissioned officers to observe and recognize abnormalities of conduct which was carried out by the American neuropsychiatrists as part of their routine duties. This is one feature of the psychiatric experiences of the first World War, which might well be immediately instituted in connection with our present mobilization tasks. 1.3 per cent of the cases were referred by the psychologists, a rather inexplicable phenomenon in view of the fact that the psychologists had a fine opportunity for observing the soldier in connection with the administration of the intelligence tests; 0.3 per cent were disciplinary cases, and in 3.1 per cent of

the cases the source of detection of the abnormalities was not ascertained.

The second important factor which undoubtedly contributed to the marked lessening of the incidence of neuropsychiatric casualties among the A. E. F. was the manner in which these casualties were managed and treated when they occurred. Before discussing this point, let me again stress the significant prophylactic work which the original elimination technique accomplished. This fact was recognized by a number of American as well as European authorities. After some little experience the average psychiatrist could rapidly survey between 100 and 150 recruits a day with reasonable accuracy. Close and trained observation and a brief but pointed conversation in connection with the physical examination enabled us to detect those who required a more detailed examination. Curiously, but perhaps not so strangely after all, the main difficulties with regard to action on the psychiatrist's recommendation were encountered at the hands of the general medical officers of the disability boards, whereas the line officers who rated their men in terms of conduct, behavior and efficiency, were extremely sympathetic and coöperative.

I dwell upon this prophylactic side of the problem because it is also the most urgent and the most important problem confronting us today in connection with our mobilization. It should be remembered that those accepted into the army in connection with the Selective Service Law are not only obliged to live under military conditions for one year but remain in the army reserve for 10 years thereafter. Apart from the personal suffering of those who might have escaped a breakdown under civil life, had their predisposition to breakdown been recognized, failure to do so creates an incredible economic burden. Of the 68,727 post-war cases under hospital care by the Veterans Administration in June 1940—twenty-two years after the termination of the first World War—20 per cent were neuropsychiatric patients.

Up to the present over one billion dollars have been expended for the care of and for the various benefits granted to these neuropsychiatric patients.

The administrative procedures which are being followed in connection with the present Selective Service Law, will undoubtedly assist the draft boards in detecting a certain number of draftees who are unfit for army life. But we must not deceive ourselves concerning the limitations and shortcomings of such a necessarily rapid and superficial survey. To

be sure, these boards will have before them a great many personal data which the draftee is obliged to supply, a careful scrutiny of which might furnish a hint which should put the examiner on guard. But I think it might help matters if the authorities charged with this important aspect of the work would carefully scrutinize the literature for technical hints in clinical situations similar to those which confront the draft boards. We all recognize the importance of time and coöperation in arriving at a psychiatric diagnosis apart from clinical technique. Permit me to refer to two situations in my own experience which in some ways are not very much unlike the situation confronting the draft boards.

Many years ago, I was engaged in the neuropsychiatric examination of immigrants at Ellis Island. In a paper published following that experience, I pointed out, among other things, that usually we had less than one minute for the preliminary scrutiny of an immigrant, as these people passed before us in single file. It was remarkable how often minor, and what appeared to be insignificant characteristics in posture, gait, general attitude and response to a question or two were sufficient to lead us to select an immigrant for a further examination, which proved to be justified in a remarkably large number of instances.

An effort was made by several of my fellow officers who shared with me the experiences at Ellis Island to examine critically what it was in the nature of hunches or techniques which assisted us in carrying out this difficult job of rapid-fire detection of neurological and psychiatric difficulties. It is estimated that the Medical Advisory Boards of the Selective Service Administration will have about 15 minutes for the secondary, and I think final examination of those suspected of having psychiatric disabilities. It would be well for them to scrutinize whatever literature there is with reference to our experiences in the examination of immigrants in those days when they were coming in at the rate of 100,000 a month at Ellis Island alone.

The other point I wish to touch upon is the importance of coöperation in arriving at a psychiatric diagnosis. Some twenty odd years ago I was engaged in the psychiatric examination of the prisoners at Sing Sing. One of the first difficulties we encountered there was the very prevalent attitude of suspiciousness on the part of the prisoners in connection with any attempt to inquire into what they called their strictly private affairs.

Besides, the benighted lot of prison guards of that day very quickly

dubbed me the "nut doctor" and very quickly succeeded in carrying over to the prisoners the idea that an interview with me meant all sorts of possibilities of further burdening their lot, and came to use it as a threat of punishment. I suppose the situation is very much different with respect to these matters today. But in those early days, when the psychiatric study of prisoners was still a novelty, we had to cope with many serious difficulties in gaining the necessary coöperation of the prisoners. We naturally tested all sorts of devices for overcoming these difficulties and one of these devices seemed to be of great assistance in giving us a hint, at any rate, as to what sort of personality we might be dealing with in a given case. As soon as the prisoner was admitted and practically while he was undergoing his preliminary ablutions, an intelligent, long term fellow prisoner, who assisted us in this work, gave the new inmate a sheet of paper and envelope and suggested that he write a letter to the doctor and address it to him in the sealed envelope. He also hinted that it was part of the prison routine, a little actual deviation from fact which the prison administration agreed to wink at. The letters we received were as a rule very revelatory, indeed, and constituted a very helpful point of departure in connection with the first interview. Especially revealing were those occasional epistles which consisted of just a blank sheet of paper and nothing else.

I am wondering whether, if time permitted, the carrying out of such additional steps in the work of the already overtaxed draft boards would not be a valuable aid in hinting at certain psychiatric difficulties which are somewhat obscure and difficult of detection. I am wondering whether it wouldn't be helpful to ask the draftee to accompany the formal questionnaire which he is asked to fill out by a private and sealed letter to the doctor on the draft board. Some things might come to light in this way which never would be revealed in the official and formal questionnaire. I am aware that in suggesting this rather unofficial and certainly, unmilitary deviation from the legal provisions of the Selective Service Law, I am not only exposing myself to the admonition that such informal and perhaps mitigating gesture might well be all right for civil life but has no place in military matters, but I'm also certain to run up against the ancient bugaboo of malingering. As far back as 1916 I published a somewhat detailed study of malingering and came to the following conclusions at that time.

1. The detection of malingering in a given case by no means excludes

the presence of actual mental disease. The two phenomena are not only not mutually exclusive, but are frequently concomitant manifestations in the same individual.

2. Malingering is a form of mental reaction manifested for the purpose of evading a particularly stressful situation in life, and is resorted to chiefly, if not exclusively, by the mentally abnormal, such as psychopaths, hysterics and the frankly insane.

3. Malingering and allied traits, viz: lying and deceit are not always consciously motivated modes of behavior, but are not infrequently determined by motives operative in the subconscious mental life, and accordingly affect to a marked extent the individual's responsibility for such behavior.

4. The differentiation of the malingered symptoms from the genuine ones is, as a rule, extremely difficult, and great caution is to be exercised in pronouncing a given individual a malingerer.

Such experience as I have had in the twenty-five years since then has confirmed me in the views expressed above. Apart from the fact that most authorities agree that the question of malingering played a very insignificant role in the psychiatric experiences of the last war, the resort to malingering on the part of the draftee, especially the malingering of a psychiatric difficulty, should in itself constitute a very strong presumption in favor of considering such an individual unfit for military service. As is so ably pointed out by Mr. Dykstra, the Director of the Selective Service Administration, in his preface to medical circular No. I: "Military life requires that the soldier shall be able to comfortably live in continued close contact with a variegated group of other men. He cannot depend on any self-evolved protective mechanism that sets him apart from his fellows. Military and naval experience is in favor of excluding from the armed forces all persons discovered to have mental or personality handicap of any material degree." Resort to malingering in an attempt to escape military service, should, in my opinion, constitute a sufficient cause for further careful psychiatric observation, if not for rejection forthwith.

It may be that I have devoted a disproportionate amount of the time allotted to me this evening to a stressing of the importance of detecting the mentally unfit draftee. But failure in this phase of psychiatric service is bound to create serious difficulties for the individual soldier as well as for the army. I am convinced, after re-reading the psychiatric

literature of the last war, that the most important contribution which psychiatry made was the prophylactic job of eliminating at the very beginning those who were unfit for military service. Many years ago, Kraepelin's Clinic at Munich issued the dictum that the mere fact of an individual's capacity to develop a psychogenic personality disorder was proof that he was burdened with what they termed a degenerative constitution. I questioned at that time the complete validity of that assertion and still question it today, though not so convincingly as in my youth. But I still doubt whether a predisposition to a failure to manage adequately the devastating experiences of modern warfare necessarily indicates a serious personality defect. The conflict between the forces which condition the desire to live and the avoidance of annihilation, on the one hand, and of those forces within the individual which are responsible for those highly complex attitudes of loyalty, patriotism and honorable behavior as a member of a group, on the other hand, may be unmanageable in the best of men. As a matter of fact, quite a few of the combatants, both officers and men, who subsequently suffered from manifestations of so-called "shell shock" had been decorated for an extraordinary display of bravery and capacity for sustained and unflinching effort under extremely harrowing situations. So that at best we cannot foresee a certain number of these casualties.

Earlier in this paper I stated that I attributed the substantially lower ratio of neuropsychiatric casualties in the A. E. F. as compared with the ratio of the B. E. F. not only to the much briefer participation of our forces in actual warfare but also to the prophylactic measures carried out in this country and to the manner of treating and managing the casualties in the A. E. F. as they occurred at the front.

Here again the country owes a great debt to the late Thomas A. Salmon. I shall briefly quote from the official history the general principles upon which the management and therapy of the neuropsychiatric casualties in the A. E. F. were based. These principles were evolved in consequence of the recommendations made by Salmon's Committee already referred to above. Stated broadly they were: "First, that it is not only in accordance with the best scientific practice to treat soldiers suffering with war neuroses as early and effectively as possible but to do so is an important contribution towards the conservation of man power and military morale; second, that a point of view regarding these disorders based upon a rational conception of their physiological and psy-

chological origin should at all times be maintained and should form the basis for medico-military effort; third, that in neuropsychiatric work, as far as the exigencies of actual service permit, responsibility and leadership should rest in the hands of those who had had special training in this department of medicine. The success attained was due, first, to a clear conception on the part of the highest military authorities of the objectives to be reached and of the general plan to be followed in attaining them, and second, to the cooperation of several hundred specialists in neuropsychiatric work in connection with combat troops, general and special hospitals, courts-martial, camps, classification boards, and prisons."

I shall leave the detailed discussion of therapy to a later section of this review. But in order to indicate by contrast how important the principles quoted above really were in keeping the casualties in the A. E. F. at a uniquely low level, I just want to mention that one way in which commentators classify the therapeutic approaches during the first World War, is to divide them into the authoritarian and the benevolent methods. During the early phases of the war, and indeed almost up to the time when the method employed in the A. E. F. became known, many psychiatric authorities, especially in the German armies, looked upon the war neuroses as akin to malingering; treatment was a matter of punishment and included such measures as isolation (solitary confinement), severe restriction of diet, transfer to excited psychotic wards, application of painful electrical currents, prolonged baths until recovery. A man named Kaufmann was the chief exponent of the most rigorous form of electrotherapy. His method consisted of three phases: (1) suggestive preparation; the patient was told that painful electrical currents would be applied which were certain to cure his condition; (2) application of strong faradic currents for one or two hours; (3) active military exercises. The cure was usually completed in one sitting. This method, originally received with great enthusiasm because of the rapid recoveries, was later generally discarded when fatal cases occurred, and permanency of results was doubted. The above is a good example of what was meant by the authoritarian approach.

The post-war generation of psychiatrists had the unique privilege and the very stimulating experience of living through a period in the history of psychiatry more exciting, more challenging and more pregnant with opportunity for service than at any time before. No one can

question the fact that the psychiatric experiences of the first World War had a great deal to do with this. But I fairly shrink from the task of compressing within the scope of a brief paper a detailed analysis of the factors which made for this cause and effect relationship.

For one thing, never before in the history of medicine had psychiatrists been called upon to deal with such incredibly large numbers of acute psychiatric casualties within such a relatively brief period of time. For another thing, owing to the almost universal presence among these casualties of at least one common etiological factor, namely, the war experience, our then-current and relatively new orientations concerning functional disorders had the first opportunity of being tested on a very large scale. While it is true that both in connection with the immediate call for doing something about these casualties as quickly as possible after their occurrence, as well as in connection with the final assessment of the total experience in the various medical histories of the first World War, various degrees of deviations, dissent and compromise with the then-valid psychoanalytic theories are clearly reflected, nevertheless, nothing emerged from this mass experience of humanity in the throes of anxiety and fear, to challenge successfully the fundamental tenets of Freudian psychology.

As a matter of fact, as soon as the medical officers, and the line officers too, realized the great therapeutic value of turning to the invalid himself for an explanation of his troubles, instead of labelling him on the basis of some preconceived general notions, the shift took place from an authoritarian to a benevolent management of war neuroses. It then also became impossible to fail to recognize, as the younger Miller puts it, that the central motive around which all the clinical manifestations seemed to collect, was the conflict between conscience on the one hand, and instinct on the other. You might substitute, if you wish, for the word conscience the word super-ego, and you might join those who are still engaged today in the fruitless enterprise of classifying and naming the instincts of man. But the essence of the matter is right here. It did not escape the notice of many army psychiatrists in both the A. E. F. and B. E. F. that the shell-shocked patient rarely suffered from an actual bodily injury; that on the contrary, the sustaining of an actual injury, which promised the reward of removal from the scene of war, actually eliminated the necessity for a neurosis. Leri's statement that hysteria never occurred in an open battle, was largely justified. They

recognized the great danger to recovery of a fixation of the initial symptoms, and implemented this by placing psychiatrists as near as possible to the front line.

Naturally, they recognized the importance of fatigue, exhaustion, the shock of nearby explosions and detonations, and the possibility of actual brain concussion; all of the factors contributing to a lessening of ego-resistance which weakened repression, disturbed the balance between the contending forces of the intrapsychic conflict and permitted the emergence of the neurotic symptoms.

The passing in review of such large numbers of war neuroses brought into sharp relief the difficulty of differentiating between the different types of disorders, since, as we know also from civilian experience, strict differentiation is much more possible when the disorder is in an advanced state. Nevertheless, it was considered to be of some therapeutic value to differentiate between the cases as sharply as was possible, and to attempt to discover outside of the great prevalence of common reactions those features which were especially characteristic of the individual invalid under treatment. At Base Hospital 117, which came to be the ideal prototype for base hospital psychiatric organization, research and therapy, the following classification was employed: Neurasthenia, psychasthenia, hypochondriasis, hysteria, anxiety neurosis, anticipation neurosis, effort syndrome, exhaustion, timorousness or state of anxiety, concussion, malingering.

It is hardly worth while to enter into a detailed consideration of the clinical manifestations which led to the above classification. The symptomatology was markedly affected by the time and place of its occurrence and by the immediate precipitating events.

Of more immediate interest is what the literature reflects regarding prognosis, in view of what world events might hold in store for us. Fundamentally, as far as prognosis is concerned, the war neuroses are subject to the same conditions which are operative in civil life. The literature reflects the opinion that prognosis is affected by the age and intelligence of the patient. Naturally, actual breakdowns or pronounced character difficulties before enlistment, and a preponderance of endogenous over exogenous factors, were of bad prognostic significance. This again focuses our attention upon the importance of weeding out the unfit before exposing them to the experiences of war. Furthermore, early treatment and the place where treatment was instituted definitely

affected the outcome, while premature discharge from treatment often led to a recurrence of symptoms. The anticipation of being discharged from treatment sometimes led to a reanimation of the disorder. If this reaction, indicative of a resistance to giving up the secondary gains of the illness, was ignored and the soldier was returned to his unit in spite of the new flare-up of symptoms, the symptoms usually became aggravated during the transport; when he finally rejoined his regiment, he was often in such a state that immediate readmission to a hospital was unavoidable. Thereafter, he occupied hospital beds for weeks or months, and relapsed after discharge. Now these types of reactions are familiar to us in civil practice and I need not dwell upon them in detail. But it is important to recognize that psychiatry could only compromise with the optimum requirements for adequate therapy in the service of military requirements up to a certain point. When these limits were exceeded failure was commonly the result.

War psychiatry, as you see, is an eminently and urgently practical affair. The requirement which was constantly urged upon the psychiatrists to restore the invalided to active duty as soon as possible and in as large numbers as possible frequently came in conflict with the therapeutic principles in the individual case. But it can be said that on the whole, as time went on, psychiatry was increasingly accorded its due recognition and gained for itself in increasing measure favorable working opportunities. Sixty-five per cent of those treated at the advanced clearing stations were returned to front line duty after a few days' treatment.

If what the future holds for us in this country includes the tragic necessity of another expeditionary force, psychiatry is bound to be infinitely better equipped than it was during our last tragic experience to deal with its problems. Of course, the conditions of warfare in 1941 and in the days ahead are very different than they were in the first World War, and unquestionably will bring with them new and untested problems.

For one thing, it is as yet impossible to assess accurately the effect of modern warfare upon the civil and non-combatant population. We are told that a certain widespread "numbness" to daily happenings is affecting large numbers of the English people. It may well be that we shall be obliged to apply to the civil population some of the lessons we learned in connection with the war effort. The techniques for producing

and maintaining the "war of nerves" have attained a high degree of perfection, and steps will undoubtedly have to be taken to insulate some people against the effects of it. For this reason it is very gratifying to know that the draft boards are exercising a very liberal attitude indeed, in the matter of weeding out the unfit. We are told that in England an increasing number of private employers are instituting morale-maintaining measures among their employees, as a defense against the effects of the "war of nerves." In all these measures, psychiatry will undoubtedly be called upon to play an outstanding role.

In conclusion I would urge upon you to read the January, 1941 issue of the American Journal of Sociology, and to re-read Freud's essay on *War and Death* and White's *Reflections on the War and After.* I recommend this, because it might help us individually to re-assess our personal equipment as men and women for its worth in meeting the tasks which will surely be thrust upon us in the days to come. We are committed as a nation to do everything in our power to resist and eventually eliminate the menace that comes to us from across the seas. One of the inescapable features of this task will be the growing necessity of converting our country into what has been termed a Garrison State, where the requirements of the military machine come before everything else, to say the least. At its worst, such a radical change from peacetime pursuits and peacetime freedoms and privileges will call for a readjustment of loyalties which the average man will surely find difficult of accomplishment.